Excellus

Group Information Form

Please complete this form in its entirety. This form is required by New York State and failure to complete could result in your policy being cancelled.

Note: Underwriting may require additional documentation during review of the form, such as the most recently filed NYS-45 (or state equivalent).

Section 1: General Group Information

1. Group Number: _____ 2. Legal Entity Name: _____

3. Tax Identification Number (EIN/TIN): _____ 4. ZIP Code for Business Physical Address: _____

5. Does your business have any employees that are currently employed by a Professional Employer Organization (PEO) or leasing company and are covered as subscribers under this policy? ☐ Yes ☐ No

6. List Owners/Partners/Shareholders and Percentage of Ownership:
(Note: If there are more than four, please attach a separate listing.)

Name: _____ _____% of Ownership
Name: _____ _____% of Ownership
Name: _____ _____% of Ownership
Name: _____ _____% of Ownership

7. Commonly Owned or Related Businesses (if applicable): _____
_____

Section 2: Group Size Regulatory Information

1. Total number of full-time employees and full-time equivalents at all locations, including subsidiaries and businesses under common control within the United States, in the prior calendar year: _____

2. Average number of owners and employees (All Full-Time and Part-Time) at all locations, including subsidiaries and businesses under common control, in the prior calendar year: _____

Section 3: Medicare Coordination of Benefits

1. Did your business employ 20 or more employees who worked at least 20 weeks in the current year? ☐ Yes ☐ No
2. Did your business employ 20 or more employees who worked at least 20 weeks in the prior calendar year? ☐ Yes ☐ No
3. Did your business employ 100 or more employees on 50% or more of your business days in the current year? ☐ Yes ☐ No
4. Did your business employ 100 or more employees on 50% or more of your business days in the prior calendar year? ☐ Yes ☐ No

Section 4: Contribution

1. Annual Employer Contribution to a single-tier: Health Savings Account $_____ Health Reimbursement Account: $_____

2. If your organization offers Excellus dental what is the monthly Employer Contribution to single tier dental? _____%

The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.

Employer Authorized Representative Signature: _____ Date: _____

Print Name: _____ Email Address:_____

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

SUPPLEMENTAL SIGNATURE FORM
WEB-ANNUAL GROUP INFORMATION FORM (AGIF)

Group Name _____

Group Number _____

I acknowledge that I reviewed the Annual Group Information Form for the 2022 calendar year in its entirety and all the information is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____ _____
Employer Authorized Representative Signature | Print Name | Date

_____ _____
Phone Number | Email Address

_____ _____ _____
Broker Signature | Print Name | Date

Please attach this form to the printed version of the WEB Annual Group Information Form and send to:

Mail:
Excellus BlueCross BlueShield
Attn: Underwriting Department
P.O Box 40091
Rochester, NY 14604-0091

Email:
AnnualGroupInformationExcellus@excellus.com

Fax:
1-800-457-2777